STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395401	A. BLDG: 00 B. WING:	05/12/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BALL PAVILION, THE STATE LICENSE NUMBER: **540302**	**5416 EAST LAKE ROAD** **ERIE, PA 16511**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey completed on May 12, 2023, it was determined that The Ball Pavilion was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=E		F 0584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0584 SS=E	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	The wheelchairs of those residents found to have been affected by the deficient practice were immediately power washed and checked by the Director of Maintenance and the Director of Nursing. One wheelchair armrest was immediately replaced by maintenance. A replacement armrest for the power wheelchair has been ordered by therapy from Wheelchairs and More. To ensure no other residents were affected, all other resident wheelchairs in the building were checked by Maintenance and were cleaned as needed that night. No other repairs were noted to be needed. To make sure the deficient practice does not recur and residents live in a clean homelike environment, Maintenance performs PMs (preventive maintenance) monthly on all wheelchairs. During this time, they check that the wheelchairs are in working order and clean them. Additionally, we will have the CNA trainer check all wheelchairs and their cushion weekly to ensure they	Completion Date: **07/11/2023** Status: **APPROVED** Date: **05/31/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0584 SS=E	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	are clean and odor free, as well as in good working order and repair. Any wheelchair not meeting expectations will be reported to the DON who will complete a work order for the chair/cushion to be cleaned and/or repaired. Any visible soil or debris that can be taken care of immediately will be done so. Director of Maintenance and/or Director of Nursing will randomly check 5 wheelchairs weekly for twelve weeks to ensure cleanliness and monitor. Nursing and Maintenance staff will be educated at the next monthly department meeting to review wheelchair cleaning policy. Maintenance will also review monthly preventive maintenance sheets at this meeting. Staff will receive a copy of the policy and sign stating they understand. Plan of correction will be reviewed monthly at QAPI for the next three months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395401	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 05/12/2023
NAME OF PROVIDER OR SUPPLIER: **BALL PAVILION, THE** STATE LICENSE NUMBER: **540302**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5416 EAST LAKE ROAD ERIE, PA 16511**		

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F 0584 SS=E	Continued from page 3 [illegible] ... Management responsibility	F 0584		
F 0656 SS=E		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0656 SS=E	Continued from page 4 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Care plan will be re-evaluted in completion and updated to ensure the following: indwelling catheter and pain for resident R7; R55 was discharged from facility (unable to care plan for UTI); weight loss, nutrition, diet, and adaptive equipment for resident R30; diabetes with insulin and anticoagulant medication for resident R14; anticoagulant medication for resident R25; and oxygen for resident R15 have been identified based on orders and care concerns identified. This will be completed by RNAC. All residents will initially be reviewed for the presence and use of indwelling catheter, presence of pain, current UTI, significant weight loss, nutrition, diet, adaptive equipment for dining, diabetes diagnosis with insulin administered, anticoagulant medication, and oxygen usage. Their care plan will be reevaluated in completion and updated to ensure all orders for the presence and use of indwelling	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0656 SS=E	Continued from page 5 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	catheter, presence of pain, current UTI, significant weight loss, nutrition, diet, adaptive equipment for dining, diabetes diagnosis with insulin administered, anticoagulant medication, and oxygen usage have been identified based on current orders and care concerns identified. All residents with such new orders/conditions will have an updated care plan completed on them as long as the orders remain present. The care plan update will be completed by RNAC. RNAC was reeducated on documentation needed. Upon quarterly assessment schedules, all residents will be re-evaluted as to the presence of such orders and the inclusion of those items in their personalized comprehensive care plan. This will be completed by RNAC as appropriate. A random audit of 5 care plans bi-weekly will be implemented to monitor for completion of review, as	

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F 0656 SS=E	Continued from page 6	F 0656	well as any updates needed at the next 3 monthly QAPI meetings. This audit will be completed by the DON. All corrections, measures, and monitoring will be reviewed at QAPI for three months.	

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F 0656 SS=E	Continued from page 7 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan for six of 17 residents reviewed (Residents R7, R55, R30, R14, R25, and R15). Findings include: Review of facility policy entitled, "Care Plan" dated 11/2022, revealed that "...each time a resident's condition indicates; a new care plan will be done to address the most current problem/concern" and "The care plan will include measurable objectives and timetables to meet each resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment." Review of Resident R7's clinical record revealed an admission date of 1/04/22, with diagnoses that included respiratory failure, pressure ulcer of the sacral region, bone infection of the sacral region, dementia and high blood pressure.	F 0656		

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F 0656 SS=E	Continued from page 8 Review of Resident R7's Quarterly Minimum Data Set (MDS-a mandated assessment of a residents abilities and care needs) assessment, dated March 22, 2023, revealed that the resident was cognitively impaired, required extensive assistance for daily care,complained of constant pain and had an indwelling urinary catheter (a tube placed and held in the bladder to drain urine). Review of Resident R7's comprehensive care plan on 5/11/23, lacked reference to Resident R7's urinary catheter and pain status. Review of Resident R55's clinical record revealed an admission date of 4/14/23, with diagnoses that included chronic kidney disease, urinary tract infection, diabetes (high blood sugar) and heart failure. Review of clinical record documentation revealed Resident R55 was started on an antibiotic on 4/23/23, for a urinary tract infection.	F 0656		

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F 0656 SS=E	Continued from page 9 Review of Resident R55's comprehensive care plan on 5/11/23, lacked reference to Resident R55's urinary status or urinary tract infection. Review of Resident R30's clinical record revealed an admission date of 1/25/20, with diagnoses that included dysphagia (difficulty swallowing food and/or liquids), dementia, and gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Review of clinical record documentation revealed Resident R30 had a significant weight loss (weight loss of 5% in the last 30-day and/or 10% in the last six months) of 12.98% in the last six months. Review of physician's orders revealed Resident R30 was on a pureed diet (texture modified diet) and utilized a divided plate and Kennedy cup (light weight spill proof drinking cup with straw)	F 0656		

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F 0656 SS=E	Continued from page 10 Review of Resident R30's comprehensive care plan on 5/11/23, lacked reference to Resident R30's nutritional status, diet orders, or adaptive equipment required for meals. Review of Resident R14's clinical record revealed an admission date of 6/21/21, with diagnoses that included diabetes, high blood pressure, and atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart). Review of Resident R14's clinical record revealed physician's order dated 9/28/22, for Eliquis (medication to prevent blood clots) 5 milligrams (mg) by mouth twice a day, Insulin Lispro (medication used to control high blood sugar) 4 units subcutaneous (sq) four times a day before meals and at bedtime, and Lantus (medication used to control high blood sugar) 18 units sq once a day at 9:00 p.m. and physician orders dated 10/11/22, for Lantus 14 units sq once a day at 6:00 a.m.	F 0656		

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F 0656 SS=E	Continued from page 11 Review of Resident R14's comprehensive care plan on 5/11/23, lacked reference to Resident R14's diabetes or usage of Insulin Lispro or Lantus as well as reference to Resident R14's atrial fibrillation and usage of Eliquis. Review of Resident R25's clinical record revealed an admission date of 8/5/16, with diagnoses that included dementia, high blood pressure, and right leg deep vein thrombosis (blood clot that formed in the leg). Review of Resident R25's clinical record revealed a physician's order dated 6/29/22, for Xarelto (medication to prevent blood clots) 10 mg by mouth daily. Review of Resident R25's comprehensive care plan on 5/11/23, lacked reference to Resident R25's history of blood clots or usage of Xarelto.	F 0656		

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F 0656 SS=E	Continued from page 12 Review of Resident R15's clinical record revealed an admission date of 6/20/18, with diagnoses including stroke with left-sided weakness, Type 2 Diabetes (affects how the body uses glucose (sugar)), dementia, mood disturbance, and high blood pressure. Review of Resident R15's clinical record revealed a physician's order dated 3/15/22, for oxygen at two liters per minute. Review of Resident R15's comprehensive care plan on 5/11/23, lacked reference to providing supplemental oxygen. Observations on 5/09/23, and 5/12/23, revealed Resident R15 lying in bed with supplemental oxygen being administered through a nasal cannula (tubing that delivers supplemental oxygen through the nose). During an interview on 5/12/23, at 11:38 a.m.	F 0656		

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F 0656 SS=E	Continued from page 13 Registered Nurse Assessment Coordinator confirmed that care plans had not been developed to address Resident R7's pain or indwelling catheter, R55's urinary tract infection, R30's nutritional status, R14's insulin, or anticoagulant, R25's anticoagulant, and R15's oxygen usage. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.11(a) Resident care plan 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 14 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Care plan will be re-evaluted in completion and updated to ensure the following: major injury from a fall for residents R11 and R23 have been identified based on orders and care concerns identified. This will be completed by RNAC. All residents will initially be reviewed for the instance of a major injury since 3/14/2023, the inception of the current software program. Their care plan will be reevaluated in completion and updated to ensure all current residents with a major injury from a fall have been identified based on orders and care concerns identified. All residents with such instances will have a care plan updated on them within 14 days of returning from the hospital after diagnostic confirmation of a major injury, may be done more frequently if deemed necessary, minor injury will have the care plan updated within 14 days of reported minor injury from fall. Upon quarterly assessment	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0657 SS=D	Continued from page 15	F 0657	schedules, all residents will be re-evaluted as to the incidence of a major injury with a fall. A care plan update will be completed accordingly per policy. This step is a double check to the step listed prior. Only the IDT does care plan updates, the RNAC is responsible for care plan updates regarding falls with major or minor injury. Unit nurses perform the incident report as it occurs. A random bi-weekly audit of 5 resident care plans based on recent major or minor injury incidents will be implemented to monitor for incidence of major or minor injury from a fall, as well as any updates needed at the next 3 monthly QAPI meetings. The audit will be completed by DON. All corrections, measures, and monitoring will be reviewed at QAPI for three months.	

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	395401	A. BLDG: __00_____ B. WING: _____	05/12/2023

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F 0657 SS=D	Continued from page 16 Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to update and/or individualize care plans for two of 17 residents reviewed (Residents R11 and R23). Findings include: Review of facility policy entitled, "Care Plan" dated 11/2022, indicated that "...each time a resident's condition indicates; a new care plan will be done to address the most current problem/concern." Review of Resident R11's clinical record revealed an admission date of 12/29/21, with diagnoses that included fractured right femur, anxiety, dementia and history of falling. Review of clinical record documentation and fall investigation tool for Resident R11, revealed that he/she fell on 2/21/23, at 7:00 p.m. resulting in a right femur fracture requiring hospitalization. There was no evidence that the care plan was updated to	F 0657		

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F 0657 SS=D	Continued from page 17 reflect the fall and interventions. Review of Resident R23's clinical record revealed an admission date of 9/1/22, with diagnoses that included high blood pressure, fractured right femur, and dementia. Review of clinical record documentation and fall investigation tool for Resident R23, revealed that he/she fell on 1/9/23, at 7:45 p.m. resulting in a right femur fracture requiring hospitalization and surgical intervention. Review of Resident R23's care plan on 5/11/23, related to fall's reflected that resident was found on the floor on 9/9/22, and failed to reflect the 1/9/23 fall that resulted in a fracture or interventions implemented as a result of the 1/9/23, fall and/or fracture. During an interview on 5/12/23, at 11:38 a.m. the Registered Nurse Assessment Coordinator	F 0657		

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F 0657 SS=D	Continued from page 18 confirmed that Resident R11 and R23's fall care plan was not updated to reflect most recent fall and/or fracture. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0657		
F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 19 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	There is only one resident that was or could be affected by the practice at the time of discovery. The drainage bag was immediately covered with a bag cover and hook placed on the foot board to keep it and the tubing off the ground. All staff working were immediately reeducated on proper procedure. No other residents could be affected at the time by this deficient practice as there is only one catheter in the building. To ensure the deficient practice will not recur, in addition to verbally meeting with all staff immediately following the identification of the deficient practice, the DON will be meeting with staff at their monthly meeting on June 27th to review policies on proper catheter care. The catheter policies have been revised to include proper covering of bag as well as the need to keep bag and tubing from touching the floor. Each staff member will receive a copy of the revised policy and sign off saying they have reviewed and	Completion Date: **07/11/2023** Status: **APPROVED** Date: **05/31/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=D	Continued from page 20 This REQUIREMENT is not met as evidenced by:	F 0690	understand. Environmental rounds on drainage bag and tubing will be conducted three times a week for 60 days. All catheters in the building will be checked. In that time it will be observed that drainage bag is properly placed on hook and not touching the ground and that bag cover is in tact. After 60 days the Infection Control RN will then conduct random spot checks weekly for an additional 30 days. All catheters in the building will be checked. Plan of correction will be reviewed for the next three months at QAPI.	

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F 0690 SS=D	Continued from page 21 Based on review of clinical records, observations and staff interview, it was determined that the facility failed to provide appropriate care regarding a urinary catheter (a tube placed and held in the bladder to drain urine) for one of 17 residents reviewed (Resident R7). Findings include: Review of Resident R7's Quarterly Minimum Data Set (MDS-a mandated assessment of a residents abilities and care needs) assessment, dated March 22, 2023, revealed that the resident was cognitively impaired, required extensive assistance for daily care, and had an indwelling urinary catheter Observations in Resident R7's room on May 10, 2023, at 9:12 a.m. and again on May 11, 2023, at 10:00 a.m. revealed that the resident's urinary drainage bag and tubing were lying on the floor without a cover over the drainage bag. Interview with the Nursing Home Administrator on	F 0690		

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F 0690 SS=D	Continued from page 22 May 11, 2023, at 10:10 a.m. confirmed that Resident R7's urinary drainage bag and tubing should not have been on the floor and should have a cover over the drainage bag. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0690		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 23 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	To correct residents found to have been affected by the deficient practice, the R7 resident's nebulizer tubing was immediately disposed of. Nebulizer machine was put away. RN brought new nebulizer tubing that was in a bag. Wound vac machine was removed from the recliner and the strap was hung on her bed rail. R15: Humidifier bottle was filled with non-distilled water. LPM was adjusted to 2lpm and was double checked by Respiratory Therapist. To ensure other residents were not effected by deficient practice, all oxygen machines in the building were checked for accurate settings. The respiratory therapist checked all nebulizers in the building. All nebulizer tubings were replaced and put in a new bag. To ensure the deficient practice does not recur, staff were immediately educated that day and over the next two days as staff rotated. Monthly	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0695 SS=D	Continued from page 24	F 0695	staff meeting is being moved to 6/2 to review policy and sign off on understanding. Respiratory therapist will provide education for all nurses. Each nurse will demonstrate how to correctly adjust the liter flow on a machine. Orders added for 3rd shift nurse to check distilled water in oxygen humidifier bottle and physician approved a standing order to titrate Oxygen 1-4 lpm to maintain an oxygen saturation level > or = to 90%. Per policy, humidifier bottle is only required if flow is greater than 4 lpm or if the resident has complaints of dryness or epistaxsis. DON and/or Respiratory therapist will check oxygen liter flow settings and compare with doctor's orders once a week x 12 weeks. Nebulizer policy has also been updated to include proper storage of tubing and mask. Nebulizer policy updated. Respiratory therapist to change out the tubing and bags weekly. Unit nurse to complete in Respiratory Therapist's absence. This policy will also be reviewed at the nurse's	

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F 0695 SS=D	Continued from page 25	F 0695	meeting. Staff will receive a copy of the updated policy and will sign saying they have reviewed and understand. DON will randomly audit 4 residents with nebulizer machines once a week for twelve weeks. All tubings were replaced. Respiratory therapist will provide education for all nurses at the next nurse's meeting. Each nurse will demonstrate how to correctly adjust the liter flow on an oxygen machine and proper storage for nebulizer tubing. Education will also include the review of the following policies due to revisions; Oxygen Concentrator Operation NU0910.35, Oxygen Administration and Humidity NU9996, and Nebulizer Operation NU7015.15. Results will be discussed monthly at QAPI for 3 months.	

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F 0695 SS=D	Continued from page 26 Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and prevent the potential spread of infection regarding respiratory care equipment according to physician orders, and failed to administer supplemental oxygen as ordered for two of 17 residents reviewed (Residents R7 and R15). Findings include: Review of a facility policy entitled, " Oxygen Concentrator (device that takes air from your surroundings, extracts oxygen and filters it into purified oxygen for you to breathe) Operation" dated November 2022, indicated that oxygen will be administered to residents at the rate ordered by the physician and per oxygen concentrator with humidifier unless otherwise ordered. Review of Resident R7's clinical record revealed an admission date of 1/04/22, with diagnoses that included respiratory failure, pressure ulcer of the	F 0695		

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F 0695 SS=D	Continued from page 27 sacral region, bone infection of the sacral region, dementia and high blood pressure. Resident R7's physician's orders dated 3/03/23, included an order for Albuterol Sulfate (medication used to open airways via nebulizer mask) nebulization solution four times a day. Resident R7 also had an order for a wound vac (vacuum machine used to remove drainage from a wound). Observations on 5/10/23, at 9:00 a.m. revealed Resident R7's wound vac machine and drainage tubing resting on top of Resident R7's nebulizer mask. During an interview on 5/10/23, at 9:35 a.m. the Director of Nursing confirmed that the nebulizer mask should be stored in a bag while not in use and the wound vac machine and drainage tubing should not have been resting on Resident R7's nebulizer mask.	F 0695		

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F 0695 SS=D	Continued from page 28 Review of Resident R15's clinical record revealed an admission date of 6/20/18, with diagnoses that included stroke with left-sided weakness, Type 2 Diabetes (affects how the body uses glucose (sugar)), dementia, mood disturbance, and high blood pressure. The clinical record also revealed a physician's order dated 3/15/22, for oxygen at two liters per minute via concentrator and to change the distilled water in the humidifier bottle every day on night shift. Observations on 5/09/23, and 5/12/23, revealed that Resident R15's supplemental oxygen concentrator was set at three liters per minute continuously, and that the humidifier bottle lacked distilled water. During an interview on 5/12/23, at 8:40 a.m. Licensed Practical Nurse Employee E2 confirmed that Resident R13's oxygen concentrator was not set at the correct liters per minute as ordered by the physician and that the humidifier bottle was empty.	F 0695		

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F 0695 SS=D	Continued from page 29 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 30 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	To correct the deficient practice so no other residents could be harmed, staff were sent to clean the nourishment refrigerator immediately. The dish machine was shut off and dishes were transported to the other high temp dish machine in the personal care building. A service call was placed right away and technician was out the same day. Technician discovered that the breaker to the booster heater had been shut off. It was turned back on and a DO NOT TURN OFF sign was placed on it. Staff working that day were reeducated on both the dish machine policy and pantry refrigerator policies. It was also reviewed what to do if the dish machine does not reach proper temperature. To ensure the deficient practice does not happen again, staff will check the cleanliness of the pantry refrigerator twice a day while stocking the pantry. Any spills will be cleaned up as soon as they are found. Checking the pantry	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/01/2023**

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F 0812 SS=F	Continued from page 31	F 0812	refrigerator for cleanliness will be added to the cook's closing checklist which is completed each night. Staff meetings will be held on May 31st to re-educate all staff on both cleaning of the pantries and dish machine temperature policies. Corrective actions will be put in place immediately if temperatures are not within acceptable range and Director of Dining will be notified. All staff will receive a copy of the policies and sign stating they understand. To monitor that the deficient practice does not recur the cooks will complete the closing checklist each night, checking the pantry refrigerator for cleanliness. Director of Dining will also make random checks twice a week, confirming area is clean. Random checks will take place for three months and will include all pantry fridges. Dish machine temperatures will continue to be checked by staff while using the machine during each shift. The cook's closing checklist	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 32 [redacted]	F 0812	was updated to include checking that dish machine temperatures were taken and within acceptable range. Director of Dining will also make random checks twice a week and initial temperature log. Random checks will take place for three months. Plan of correction will be reviewed at QAPI for three months.	
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395401	A. BLDG: __00_____ B. WING: _____	05/12/2023

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F 0880 SS=D	Continued from page 33 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	To correct any residents have been affected by this deficient practice, To identify any other residents that were affected by this deficient practice, the Wound RN immediately reviewed the correct procedure for donning and doffing of gloves and hand hygiene. The infection control nurse will educate all nurses on proper infection control and hand hygiene now and yearly. Infection control nurse will join on wound rounds for a minimum of two weekly rounds a month for 3 months. This will allow her to witness all dressing changes, not just limited to wound vac changes. To ensure the deficient practice does not recur, the hand washing/hand hygiene policy will be reviewed Wound RN and she will sign stating she has reviewed and understands the policy. The dressings/prevention of infection policy will also be reviewed with eh Wound RN and she will sign stating she has reviewed and understands	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/01/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 34 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	the policy. To monitor that this does not happen again the infection control nurse will witness wound vac changes and all other wound changes. A checklist will be provided and present during each wound round completed for that week. Proper procedure for glove use and hand hygiene will be monitored by the infection control nurse for 60 days. Both nurses will initial at that time when the task is completed within the correct steps. In addition, random audits will be conducted weekly for an additional thirty days and signed off by the infection control nurse. Plan of correction will be reviewed at QAPI for the next three months.	

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F 0880 SS=D	Continued from page 35	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 36 Based on review of facility policy, clinical records, observations, and staff interview, it was determined that the facility failed to prevent the potential for cross contamination during a dressing change for one of two residents with pressure ulcers requiring wound care reviewed (Resident R7). Findings include: Review of the facility policy entitled, "Dressings/Prevention of Infection," dated 11/15/2022, indicated to remove the soiled dressing, remove soiled gloves and then wash hands. Review of Resident R7's clinical record revealed an admission date of 1/04/22, with diagnoses that included respiratory failure, pressure ulcer of the sacral region, bone infection of the sacral region, dementia and high blood pressure. Review of Resident R7's physician's orders dated 3/03/23, included an order to cleanse the sacral	F 0880		

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F 0880 SS=D	Continued from page 37 wound and apply a wound vac (vacuum machine used to remove drainage from a wound). Observation of wound care on 5/10/23, at 9:00 a.m. revealed that the Director of Nursing moved the garbage can closer to Resident R7 with their gloved hands and then proceeded to remove the soiled dressing without removing gloves or washing hands and then continued to cleanse the wound without removing gloves or washing hands. During an interview on 5/10/23, at 9:35 a.m. the Director of Nursing confirmed he/she did not change gloves and did not complete hand hygiene when indicated. 28 Pa. Code 201.18 (b)(2) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0880		

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P 0630		P 0630		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0630	Continued from page 1 § 201.22(j) Prevention, control and surveillance of TB. (j) New employes shall have the 2-step intradermal skin test before beginning employment unless there is documentation of a previous positive skin reaction. Test results shall be made available prior to assumption of job responsibilities. CDC guidelines shall be followed with regard to repeat periodic testing of all employes. This REGULATION is not met as evidenced by:	P 0630	Because all staff have tested negative for a latent TB infection prior to starting employment no residents would be affected by the deficient practice. No other residents would have potential to be affected by the same deficient practice. To ensure that the deficient practice does not recur, the two-step Mantoux was immediately reinstated. Occupational Health was called by the Director of HR and the Quantiferon Gold test discontinued effective immediately. All supervisors and human resources staff were updated with the change. All paperwork was updated immediately to reflect the change. Human resources has a checklist for all new employees in their file and signs off once paperwork with the two-step has been received. Hiring supervisors, Human Resources and Nurses were immediately educated as to the deficient practice and the need to go back to two step testing. Policy was reviewed with all.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/01/2023**

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P 0630	Continued from page 2	P 0630	Corrected forms were distributed to staff appropriately to begin using with new hires. To monitor that the deficient practice will not recur, Human Resources will monitor all new staff and check that the two step Mantoux is done prior to start date. This will continue for three months or until waiver is approved and documentation is in facility stating such. Nursing home administrator will keep a list of all new hires for three months and will verify their two step Mantoux was completed. Plan of correction will be reviewed at QAPI for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0630	Continued from page 3 Based on review of facility policy, personnel records, and staff interviews, it was determined that the facility failed to complete the two-step intradermal tuberculin (TB) skin test (injection given under the skin to test for tuberculosis) for five of five new employees prior to employment (Nursing Employees E2, E4, and E5, Activity Employee E6, and Dietary Employee E7) Findings include: Review of facility policy dated 11/2022, entitled "Mantoux Test - Health Assessment for Employees to Test for Tuberculosis" indicated that "All employees to receive a Mantoux test upon hire" and "Two-step testing is used and if a reaction to the first test is negative, a second test should be done 1 to 3 weeks later." Review of personnel record for Employee E2 revealed that Employee E2 was hired on 3/7/23. There was no documented evidence that Employee E2 received the first or second step of a two-step	P 0630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0630	Continued from page 4 TB test prior to start of employment. Review of personnel record for Employee E4 revealed that Employee E4 was hired on 1/9/23. There was no documented evidence that Employee E4 received the first or second step of a two-step TB test prior to start of employment. Review of personnel record for Employee E5 revealed that Employee E5 was hired on 2/6/23. There was no documented evidence that Employee E5 received the first or second step of a two-step TB test prior to start of employment. Review of personnel record for Employee E6 revealed that Employee E6 was hired on 1/10/23. There was no documented evidence that Employee E6 received the first or second step of a two-step TB test prior to start of employment. Review of personnel record for Employee E7 revealed that Employee E7 was hired on 2/13/23. There was no documented evidence that Employee	P 0630		

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P 0630	Continued from page 5 E7 received the first or second step of a two-step TB test prior to start of employment. During an interview on 5/12/23, at 11:00 a.m. Nursing Home Administrator (NHA) stated that within the last year the facility started doing the Quantiferon TB Gold test (alternative TB blood test method to the two-step) in place of the two-step Mantoux. NHA confirmed that the facility failed to obtain the required exception to be able to use the Quantiferon TB Gold test and that as a result Employees E2, E4, E5, E6, and E7 should have had the two-step Mantoux test, which the facility failed to do.	P 0630		
P 2000		P 2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 2000	Continued from page 6 § 211.12(f)(1) Nursing services. (f) In addition to the director of nursing services, the following daily professional staff shall be available: (1) The following minimum nursing staff ratios are required: Census / Day / Evening / Night 59 and under / 1 RN / 1 RN / 1 RN or 1 LPN 60/150 / 1 RN / 1 RN / 1 RN 151/250 / 1 RN and 1 LPN / 1 RN and 1 LPN / 1 RN and 1 LPN 251/500 / 2 RNs / 2 RNs / 2 RNs 501/1,000 / 4 RNs / 3 RNs / 3 RNs 1,001/Upward / 8 RNs / 6 RNs / 6 RNs This REGULATION is not met as evidenced by:	P 2000	To correct the deficient practice immediately, the nurse's schedule for 7p-11p was updated to include RN coverage for the remainder of the current schedule. No other residents were affected by the deficient practice as there was RN coverage. To ensure the deficient practice does not recur, an RN on call policy was created. All RNs were educated on the coverage requirements immediately. All RNs and LPNs will also receive a copy of the new policy and will review it with the DON at the next nurse's meeting. Once reviewed they will sign stating they have received a copy and understand. RNs will be scheduled in the building from 7a-11p. The typical schedule being 7a-7p and 7p-11p, which includes the 3p-11p shift. The new RN on call policy only allows an RN on call from 11p-7a if the facility census is <59. The DON and Nursing Home	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/01/2023**

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P 2000	Continued from page 7	P 2000	Administrator will monitor that the deficiency does not recur by reviewing the nursing schedule when it is posted monthly and ensure required coverage is scheduled. At the end of each week, DON will check shifts actually worked against the schedule to ensure there was RN coverage for the entire week. Monitoring will continue for three months. Plan of correction will be discussed monthly at QAPI for 3 months.	

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P 2000	Continued from page 8 Based on review of nursing hour schedules and staff interview, it was determined that the facility failed to maintain a Registered Nurse (RN) on the evening shift as required for 12 of 21 days reviewed (11/06/22, 11/09/22, 11/10/22, 4/11/23, 4/12/23, 4/13/23, 4/14/23, 5/04/23, 5/07/23, 5/08/23, 5/9/23, and 5/10/23). Findings include: Review of three weeks of nursing hour schedules revealed that the facility failed to maintain required RN coverage for the required time on the evening shift (3:00 p.m.-11:00 p.m.) on the following dates 11/06/22, 11/09/22, 11/10/22, 4/11/23, 4/12/23, 4/13/23, 4/14/23, 5/04/23, 5/07/23, 5/08/23, 5/9/23, and 5/10/23, 12 of 21 evening shifts reviewed. During an interview on 5/11/23, at 8:53 a.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility RNs work 12-hour shifts from 7:00 a.m. to 7:00 p.m. and that	P 2000		

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P 2000	Continued from page 9 the facility is staffed with Licensed Practical Nurses from 7:00 p.m. to 7:00 a.m. due to a facility census below 60 and was without RN coverage from 7:00 p.m to 11:00 p.m. on the above dates.	P 2000		

Certified End Page

BALL PAVILION, THE

STATE LICENSE NUMBER: 540302

SURVEY EXIT DATE: 05/12/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY